Communicable Disease UPDATE

Newsletter of the Bureau of Communicable Disease Control, Massachusetts Department of Public Health Vol. 13, No.2 Spring 2005

Lymphogranuloma Venereum (LGV) in Massachusetts

In the fall of 2004, a Morbidity and Mortality Weekly Report (MMWR-October 29, 2004/53(42):985-988) of the Centers for Disease Control and Prevention (CDC) alerted clinicians to an increase in the number of cases of LGV among men who have sex with men (MSM) in the Netherlands. Typically, fewer than 5 cases a year were reported in that country. As of September 2004, a total of 62 cases occurred. Except for one, all patients had gastrointestinal symptoms (e.g. bloody proctitis with purulent or mucous anal discharge, tenesmus and constipation). Some patients in this LGV outbreak had reported multiple sex partners in cities in Europe and the United States. This report prompted increased surveillance and awareness of this disease in the United States.

LGV is caused by *Chlamydia trachomatis* (CT) serotypes L1, L2 and L3. LGV is a rare disease in the United States. A few confirmed cases have now been reported in cities across the US. In Massachusetts, nine cases have been determined to be rectal LGV. Suspected cases continue to be investigated. Most of the cases reported in the United States are in MSM who presented with similar symptoms as the cases in the Netherlands. Clinicians should be aware of this clinical presentation of LGV. CDC advises clinicians who care for MSM to consider LGV in the diagnosis of compatible syndromes (e.g. proctitis and proctocolitis) and perform tests to diagnose *C. trachomatis* infections without regard to the specific LGV serotypes.

Diagnosis of LGV

Diagnosis is based on clinical findings, supported by direct identification of CT by culture nucleic acid testing or by serologic tests for CT infection. Serologic testing, which has not been well standardized, is not considered specific for LGV, but may support a clinical diagnosis. Direct identification by commercially available methods is also not specific for LGV serovars of CT. Use of rectal swabs for nucleic acid testing has not been cleared by the U.S. Food and Drug Administration, but has been validated by some health department laboratories. The CDC is collaborating with health departments to assist in the laboratory diagnosis of LGV with specialized amplified nucleic acid testing.

Treatment of LGV

The recommended treatment for LGV is doxycycline, 100 mg, orally, twice a day, for 21 days. Alternative treatment is 500

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New Meningococcal Vaccine Licensed: Expanded Recommendations for Adolescents

In January 2005, the U. S. Food and Drug Administration (FDA) licensed a new meningococcal quadrivalent conjugate vaccine (MCV4), Menactra™, for use in people 11 – 55 years of age. MCV4 is manufactured by sanofi pastuer (formerly knows as Aventis Pasteur) that will help protect against invasive meningococcal disease.

Following the licensure of MCV4, the Advisory Committee on Immunization Practices (ACIP) voted in February to expand its recommendations for meningococcal vaccine to now include the following groups:

- children at their routine preadolescent visit (11 – 12 years of age);
- adolescents at high school entry (15 years of age) for the next 2 – 3 years;
- incoming college freshmen living in dormitories; and
- other groups at high risk (including military recruits; those traveling to or residing in countries where meningococcal disease is epidemic; those with functional or anatomic asplenia; terminal complement deficiency; microbiologists who are routinely exposed to isolates of meningococcal bacteria; people who may have been exposed to meningitis during an outbreak).

With the licensure of MCV4, two meningococcal vaccines are now available in the United States. Meningococcal polysaccharide vaccine (MPSV4), Menomune®, is also manufactured by sanofi pasteur. Both vaccines provide protection against the same four serogroups of *Neisseria meningitidis* (A, C, Y and W-135). MCV4 differs from MSPV4 in that it is expected to provide longer lasting immunity, reduce person-to-person transmission and provide herd immunity by reducing nasopharyngeal carriage.

MCV4 is the preferred vaccine for individuals 11 – 55 years of age. However, MSPV4 can be used if MCV4 is not available. MPSV4 is the only meningococcal vaccine currently licensed for use in children 2 – 10 years and adults > 56 years of age.

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Look Inside!

Epidemiology

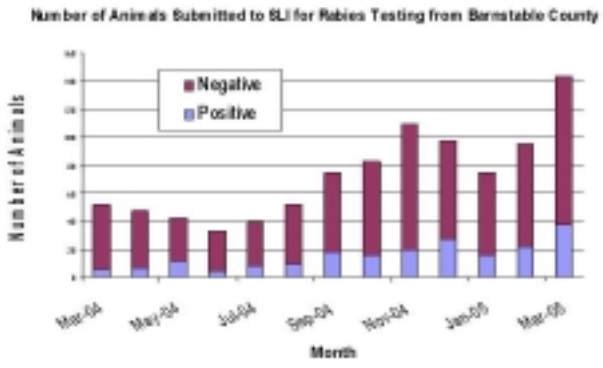
Rabies on Cape Cod: A Rapidly Emerging Public Health Issue

While bat strain rabies has been identified throughout Massachusetts since 1961, raccoon strain rabies only entered the state in 1992. In 1994, the Tufts University School of Veterinary Medicine, the U. S. Department of Agriculture and the Massachusetts Department of Public Health (MDPH) initiated an oral rabies vaccine (ORV) program to try to prevent the raccoon strain of rabies from reaching Cape Cod.

The ORV program utilizes fish meal baits that are specifically attractive to raccoons that contain rabies vaccine . Since 1994, the baits have been distributed in 11 towns on the western side of the Cape Cod Canal every fall and spring along roadsides in wooded, brush covered, and wetland areas where raccoons are likely to find and eat them.

The program had been very successful, and no raccoon strain rabies was found on the Cape for over 10 years. However, in March of 2004, the first positive raccoon was identified in Bourne on the Cape side of the canal. Since then, 243 terrestrial animals from Barnstable County have tested positive for rabies, including 206 raccoons, 34 skunks, one coyote, one fox and one otter. Positive animals have been found as far east as Eastham. Surveillance remains ongoing in all towns on the Cape.

In response to the discovery of the first rabid raccoon on Cape Cod, the MDPH, Division of Epidemiology and Immunization has been working closely with local health officials on the Cape to educate healthcare providers, veterinarians, law enforcement agencies, schools, camps and the general public about the presence of rabies and ways to minimize people's contact with potentially rabid animals. New educational materials were developed, including bookmarks, kiosk cards, and a PowerPoint presentation for elementary school children. All materials are available on the MDPH rabies website at www.mass.gov/dph/cdc/epii/rabies/rabies.htm or by calling the MDPH at 617-983-6800. To improve awareness further, a well-attended press conference was held in cooperation with the Cape Cod Rabies Task Force in Barnstable County to kick off Rabies Awareness Month in April.



Eastern Equine Encephalitis (EEE)

EEE is a viral illness spread by mosquitoes. The mortality rate is high and survivors often suffer neurological damage. The first human case of EEE was identified in Massachusetts in 1938. Since then, 79 people in Massachusetts have been identified with EEE and over half of them died.

EEE is endemic in eastern and southern Massachusetts, specifically Plymouth, Bristol, Norfolk, Suffolk, and Middlesex counties. The highest risk for EEE is normally from late July through September.

Infection with EEE virus commonly presents as encephalitis (inflammation of the brain). The incubation period is 3-10 days. Symptoms of EEE may include fever, headache, stiff neck, lethargy, and confusion. People under 15 or over 50 years of age are at greatest risk for serious illness.

While EEE is relatively rare, Massachusetts has experienced periodic outbreaks. In 2004, four human cases were identified, two of whom died. MDPH is concerned about the potential for disease transmission in 2005. Outbreaks of EEE in the past have occurred in two-year cycles, with the second year being worse than the first. Given the cases identified in 2004, we may see a higher number of cases this coming summer. Also, Massachusetts experienced a winter with large amounts of insulating snow cover allowing for a larger number of mosquito larvae to survive. Winter surveillance of mosquito populations indicated above average larval mosquito counts in EEE prone areas. The risk for EEE may be increased earlier in the season as these over-wintering larvae emerge this spring.

In 2004, EEE virus was detected outside of the usual higher-risk southeastern Massachusetts area. Two EEE virus positive mosquito pools, two positive horses and a positive alpaca were identified in northern Middlesex County. In addition, an EEE virus positive emu and horse were identified in Essex County.

There is no human vaccine for EEE. MDPH recommends:

Avoid outdoor activities between dusk and dawn, when mosquitoes are most active.

- Avoid swamps or marshlands, where mosquitoes that trans mit EEE virus are most abundant.
- Wear a long-sleeved shirt and long pants and cover up the arms and legs of children when outside during high risk times or in high risk areas.
- Fix any holes in screens and tightly attach them to all doors and windows.
- Use repellents containing DEET (N, N-diethyl-m-toluamide) and choose a product that will provide sufficient protection for the amount of time spent outdoors. DEET should not be used on children less then 2 months of age and should be used in

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Massachusetts 2004 Birth Hospital Record Review

In 2004, the Massachusetts Immunization Program (MIP) repeated a birth hospital record review previously conducted in 2000 and 1995. The purpose of the record review was twofold:

- to evaluate compliance with national recommendations and Massachusetts regulations regarding administration of the birth dose of hepatitis B vaccine, prenatal screening and documentation of HBsAg and rubella immunity, and administration of a rubella-containing vaccine to rubella-susceptible postpartum women; and

- to monitor compliance with administration of the birth dose of hepatitis B vaccine after the temporary hiatus in the routine administration of the first dose of hepatitis B vaccine at birth due to concerns about thimerosal.

Coincidentally, the 2000 birth hospital record review analyzed records of infants born in the 6 months prior to the hiatus (January to June 1999), and the 2004 review analyzed records of infants born one full year after Massachusetts birth hospitals had reinstated a policy of routine administration of the birth dose of hepatitis B vaccine (July to December, 2001).

The results of the 2004 record review confirmed that all birth hospitals in Massachusetts had reinstated a policy of administering the birth dose of hepatitis B vaccine, regardless of the mother's HBsAg status, and that ninety-two percent (92%) of infants had received hepatitis B vaccine at birth, compared to 91% in 2000 and 89% in 1995.

The Massachusetts Department of Public Health believes it is essential that Massachusetts birth hospitals continue the systematic administration of the first dose of hepatitis B vaccine at birth. Medical errors in perinatal hepatitis B prevention can occur in hospitals, as well as in primary care settings. Unfortunately, there have been documented cases of hepatitis B infection in the U.S. in infants born to HBsAg-positive mothers, including fatalities, due to inaccurate transcription or interpretation of prenatal HBsAg laboratory results. Administration of the first dose of hepatitis B vaccine at birth provides some margin of safety to reduce the impact of such errors. Since the birth dose policy has been in place in Massachusetts, **no** case of perinatal hepatitis B has occurred due to a failure to administer appropriate hepatitis B prophylaxis.

Further analysis of the data gathered during the 2004 birth hospital record review indicates that Massachusetts birth hospitals, obstetric providers, and pediatric providers demonstrate excellent adherence to recommendations and regulations regarding screening for HBsAg (99%) and rubella immunity (99%). Notably, sixty-three percent (62%) of rubella-susceptible or "status unknown" women had documentation of having received a rubella-containing vaccine prior to hospital discharge, which was up from 0% during the 2000 record review.

New Meningococcal Vaccine License

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In March 2005, MCV4 vaccine distribution began in this country. While limited amounts of the vaccine are currently available, the manufacturer expects production to increase over the next several months, so that 5 million doses should be available by February 2006. However, initial national supplies of MCV4 will not be sufficient to vaccinate all three of the recommended cohorts.

MDPH does not expect to be able to provide MCV4 until sometime after July 2005 when state and federal funding for vaccines is finalized. However, funding and supply are not expected to be sufficient to fully cover all three of the recommended cohorts in the first year of vaccine distribution. As more information becomes available, MDPH will inform providers and third party payors about the status of state-purchased vaccine and the groups for whom it will be prioritized.

Providers may need to purchase meningococcal vaccine privately from Sanofi Pastuer. The current procedural terminology (CPT) code for Menactra™ is 90734. The CPT code for Menomune® is 90733. Providers are encouraged to contact their third party payors regarding coverage for these vaccines.

A new interim vaccine information statement (VIS) for meningococcal vaccines (combined conjugate and polysaccharide) dated April 4, 2005, is now available at www.immunize.org/vis. The new VIS must be used if MCV4 is being administered. The old VIS dated July 28, 2003, can be used if MPSV4 is being administered.
The ACIP's recommendations on the Prevention and Control of Meningococcal Disease are expected to be published in late May. All ACIP recommendations can be found at www.cdc.gov/nip/ACIP.

Separate from the new ACIP recommendations for meningococcal vaccine, state regulations pertaining to meningococcal vaccination for residential schools with grades 9 – 12 and postsecondary institutions that provide or license housing were recently promulgated. Information about these new school entry requirements can be found at www.mass.gov/dph.

HIV/AIDS Surveillance

AIDS and Tuberculosis in Massachusetts: Implications for Health Care Providers

Matching of the AIDS and tuberculosis (TB) case registries has been conducted routinely since 1993. Tuberculosis in individuals with HIV infection is an AIDS-defining condition. Cumulative AIDS cases reported through December 2004 were matched to incident TB cases (1982-2004) in February 2005. A total of 656 matches were identified, a two percent increase in total co-morbidity from the previous match in 2004. The 656 cases constitute 8% of TB cases reported from 1982-2004 and 4% of AIDS cases through 2004.

When compared with AIDS cases without TB, TB/AIDS cases were:

1. More likely to be non-white, foreign-born, and resident in the City of Boston;
2. Less likely to report a history of male-to-male sexual contact as a mode of exposure for HIV infection; and
3. More likely to have a presumptive heterosexual or unidentified HIV risk.

This annual registry match supports an ongoing effort to evaluate the completeness of TB reporting. It also assesses the adequacy of the TB case definition among persons reported with AIDS and TB.

HIV infection increases the risk of reactivation of latent TB infection and accelerates the progression disease. In addition, HIV-infected persons are thought to be more likely to become infected with tuberculosis after exposure than are persons with intact immunity. Active TB disease also appears to accelerate the course of HIV disease. Co-infection is associated with a higher plasma virus load and with accelerated rates of decline in CD4 count.

It is important that people with TB be assessed for HIV risk/infection, as it may affect their treatment. Management of HIV-related TB is complex and requires expertise in the management of both HIV infection and TB. HIV counseling and testing should be offered in **all** confirmed and suspected cases of TB. In addition, an HIV risk assessment should be done for all contacts to infectious TB cases and people with latent TB infection.

Epidemiology Program Announcements

Check out the "Emergency Dispensing Sites Management and Operations" (EDS) guidance that is available on the MDPH website www.mass.gov/dph/bioterrorism/advisorygrps/pdfs/emergency_dispensing_site_3_05.pdf. It includes detailed information to help local boards of health develop their EDS plans.

HIV/AIDS Among Women in Massachusetts

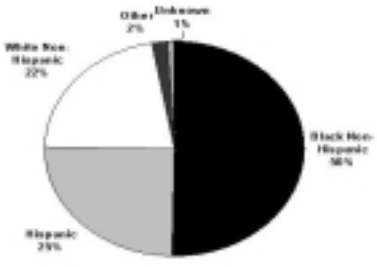
At the onset of the epidemic in Massachusetts, almost all cases of HIV/AIDS were diagnosed in men. However, over time, women have become an increasing proportion of newly diagnosed cases in Massachusetts, and in turn, a growing number among persons living with HIV/AIDS. Currently, 30% of people recently diagnosed with HIV infection and 28% of people living with HIV/AIDS in Massachusetts are women. As of July 1, 2004, there were 4,167 women living with HIV/AIDS.

Reported HIV/AIDS cases demonstrate that black and Hispanic women are at higher risk for HIV/AIDS. Black women represent 50% of recent HIV infection diagnoses in women, compared to black men who represent 26% of recent HIV infection among men. Similarly, among people living with HIV/AIDS, 39% of the women are black, compared to 22% of the men. Black females are 20 times more likely to be living with HIV/AIDS and Hispanic females 13 times more likey than white females.

The mode of acquisition of HIV infection for women in Massachusetts also varies across race/ethnicity. While injection drug use is the predominant mode of exposure among white women (accounting for 34% of women recently diagnosed with HIV infection and 52% of women living with HIV/AIDS), heterosexual sex is the predominant exposure among black women (accounting for 56% of women recently diagnosed with HIV infection and 41% of women living with HIV/AIDS). Heterosexual sex is also the predominant exposure among Hispanic women (accounting for 41% of women recently diagnosed with HIV infection and 44% of women living with HIV/AIDS).

Black and Hispanic women represent less than 12% of women in the state, yet they account for more than 64% of HIV/AIDS cases in women. Even with the availability of highly active antiretroviral therapy, addressing disparities in care, preventing vertical transmission, and meeting the social and medical needs of women living with HIV/AIDS or at risk for HIV infection remains a significant public health challenge, especially for women of color.

Figure 1 Women Diagnosed with HIV Infection from 2001-2003 by Race/Ethnicity: Massachusetts



STD

Sexual Behavior in Massachusetts High School Students: Implications for Clinicians

The Massachusetts Youth Risk Behavior Survey (MYRBS) is a student health survey that is conducted every two years by the Massachusetts Department of Education, with funding from the U.S. Centers for Disease Control and Prevention (CDC). The purpose of this voluntary, anonymous survey is to monitor the prevalence of adolescent risk behaviors that have a potentially negative impact on student learning and may ultimately lead to illness and injury. These risk behaviors include tobacco use, alcohol and other drug use; behaviors related to intentional and unintentional injuries; poor dietary patterns; lack of physical activity; and high-risk sexual behavior.

The most recent MYRBS was conducted in the spring of 2003 and included fifty randomly selected public high schools across the state. The size of the sample was 3,624 students. Key survey findings (regarding sexual behaviors) indicate decreases in the proportions of students who report:

- Lifetime sexual intercourse (49% in 1993 to 41% in 2003);
- Sexual intercourse before age 13 (8% in 1995 to 6% in 2003);
- Four or more lifetime sexual partners (15% in 1995 to 10% in 2003); and
- Having ever been or gotten someone pregnant (7% in 1997 to 4% in 2003).

Among students who were sexually active in the three months before the survey:

- One-quarter (25%) used alcohol or drugs before their most recent sexual intercourse. This is a slight increase from 23% in 2001.
- Over half (57%) used a condom during their last sexual intercourse – a modest increase over 52% in 1993.
- Male and female students were equally likely to report having had sexual intercourse in their lifetimes (41% for each group).
- Hispanic students (45%) were significantly more likely than black students (31%), white students (28%), and Asian students (24%) to report recent sexual intercourse.
- Urban students were significantly more likely than non-urban students to report lifetime sexual intercourse and sexual intercourse before age thirteen.

While reports of decreases in students engaging in sexual intercourse may be encouraging, the survey results reflect the reality that many high school students are sexually active and nearly half did not use a condom the last time they had sexual intercourse. Condom use was significantly less common among students in older grades who were more likely to be sexually active. One-quarter of all sexually active students used alcohol or drugs before the last time they had sexual intercourse. There has been a significant increase in the percentage of students who have been diagnosed with a sexually transmitted disease (STD).

In light of these trends, the Massachusetts Department of Public Health encourages all providers to:

1) **Perform a sexual history at least annually for all adolescents in their practice.**
   It's also important to take a drug and alcohol use history, as they often play a central role in the sexual activity of adolescents, placing them at higher risk of engaging in sex, particularly unprotected sex.

2) **Screen all sexually active teens for STDs, particularly *Chlamydia trachomatis* infection.**
   Age is the single most important predictor of chlamydial infection. The CDC and professional organizations recommend annual chlamydia screening for all sexually active women age 25 and under. It may be appropriate to screen adolescents more frequently. In Massachusetts, as in most other states, the law permits testing for STDs without parental consent.

3) **Take advantage of every opportunity to provide adolescent patients with education and prevention messages to keep them safe and healthy.**
   Helpful tips to engage young people when talking about sexual behaviors include avoiding lectures or confrontation and acknowledging that change can be difficult; engaging the adolescent in a dialogue to assess their knowledge and fill in any information gaps; focusing on his/her personal risk and circumstances; helping the teen to set and reach specific goals; and acknowledging and complimenting the teen on any positive attempts at risk reduction.

The Division of STD Prevention, in collaboration with the Office for Medicaid, the University of Massachusetts Medical School and the STD/HIV Prevention Training Center of New England, has created a toolkit for clinicians to assist in the prevention and management of chlamydial infections in adolescents. It contains patient education materials, tips on making the office teen friendly, information on confidentiality, how to conduct a sexual history and prevention counseling, as well as screening and treatment recommendations. The toolkit is available online at http://www.state.ma.us/dph/cdc/std/divstd.htm.

Refugee and Immigrant Health

Refugee Health Web Resources

Increasingly, health care providers, public health programs, community agencies and consumers turn to the World Wide Web for health information. Because information sources vary, validating the quality and accuracy of health information is important. When materials are in languages other than English, additional challenges to validation – such as cultural appropriateness and translation quality – are introduced.

The National Library of Medicine (NLM), directly and through the National Network of Libraries of Medicine (NNLM), has supported the development of web sites that promote electronic access to health information for refugee and immigrant communities and medical providers serving these communities. We highlight three web resources – two are particularly relevant to recently resettled refugee populations (Hmong and Somali) and a team in Boston (South Cove Community Health Center and Tufts University Health Sciences Library) developed the third.

The **Hmong Health Education Network** has a bilingual Hmong-English web site [www.hmonghealth.org] funded by NLM and managed by the Northern Wisconsin Area Health Education Center. The site has extensive information on specific health topics, traditional approaches to health and wellness, and an annotated health dictionary. Approximately 15,000 Hmong refugees have been or will be resettled in the US from Wat Tham Krabok in Thailand. While fewer than 100 are expected to resettle in Massachusetts, this web site will allow providers access to quality information.

EthnoMed [www.ethnomed.org] is a website containing medical and cultural information on immigrant and refugee groups. It is a joint project of University of Washington Health Sciences Library and the Harborview Medical Center's Community House Calls Program. NLM provides partial support for the project. The EthnoMed site includes print, audio and video materials for providers and patients. Ethnic/cultural groups included are Amharic, Cambodian, Chinese, Eritrean, Hispanic, Oromo, Somali, Tigrean and Vietnamese.

SPIRAL: Selected Patient Information Resources in Asian Languages [http://www.library.tufts.edu/hsl/spiral/web.html] is a joint initiative of South Cove Community Health Center and Tufts University Health Sciences Library that is supported by the NNLM. This site is designed to meet the consumer and health care provider needs of the South Cove community, with consumer information in Chinese, Cambodian/Khmer, Hmong, Korean, Lao, Thai and Vietnamese.

The Refugee Health Information Network (RHIN) is a web resource in development. With funding from NLM, this site is designed to be a refugee health resource for consumers and providers. The RHIN partnership includes the Center for Public Service Communications, Georgetown University Medical Center, and refugee health programs in California, Florida, Illinois, Massachusetts and Texas. In Massachusetts, the Refugee and Immigrant Health Program will work with the Refugee Health Assessment Program provider network to test and develop the site. We expect public release before the end of 2005.

Refugee Health Assessment Program Provider Network

Massachusetts has utilized a provider network for the delivery of refugee health assessments since 1995. These health care providers have expertise in serving newly arrived refugees and asylees, and have adapted to increasingly diverse populations and their language needs. Funding for services is from the federal Office of Refugee Resettlement through the Massachusetts Office for Refugees and Immigrants.

The most recent competitive procurement cycle sought proposals for contracts that will be effective July 1, 2005. We are pleased to announce that eight community health centers and two hospital outpatient clinics will receive contracts. We recognize the commitment that each site makes, not only to serve the newest members of their communities, but also to being part of a network of providers that together assure that refugees and asylees will have access to high quality services.

The Refugee Health Assessment Provider network, by geographic region, is:

Metro Boston:	International Clinic at Boston Medical Center MGH Chelsea Health Center, St. Elizabeth's Medical Center, Brighton Whittier Street Health Center, Roxbury
Southeast:	Brockton Neighborhood Health Center
North Shore:	Lynn Community Health Center
Merrimack Valley:	Lowell Community Health Center
Central:	Great Brook Valley Health Center, Framingham Great Brook Valley Health Center, Worcester
West:	Caring Health Center, Springfield

Update on the Hepatitis A Outbreak In MA

The outbreak of hepatitis A that began at the end of 2003 is continuing with above average numbers of cases being reported each month. The numbers of reported cases peaked in August 2004 at 120 cases. Although they have been declining since then, MDPH is still receiving reports of approximately 30 cases each month. While it is encouraging that the numbers have decreased, they are still well above what is typical, and sustained vaccination of high-risk populations and education efforts are needed to ensure that the decline continues.

Northeastern TB Regional Training and Medical Consultation Center: New England Area

We are pleased to announce that the Massachusetts Division of Tuberculosis Prevention and Control (MDTBPC) has partnered with the CDC-funded New Jersey Medical School National Tuberculosis Regional Training and Medical Consultation Center (RTMCC), and the Medical Foundation of Massachusetts, to become the New England coordination site for TB education, training and clinical consultation activities.

This designation follows years of regional educational efforts on the part of the MDTBPC and regional partners in response to the IOM report *Ending Neglect The Elimination of Tuberculosis in the United State,* as well as the national goals of the *Strategic Plan for Tuberculosis Training and Education*. These goals are to:

- Build, strengthen and maintain collaboration among key agencies and organizations
- Develop, improve, facilitate access to and maintain availability of TB training and education resources
- Improve and sustain knowledge, skills and practices tailored to local epidemiological circumstances
- Provide a mechanism for the sharing of TB education and training resources to avoid duplication of efforts

The new CDC-funded RTMCC now formalizes an education collaborative among New England states and a variety of TB-related agencies in the northeast that has existed for some time.

The New England Area team will build on earlier collaborative efforts, provide the resources to continue expansion of educational services, increase access to TB courses, increase the capacity to share faculty and material, and assist in the development of regional training programs to address TB educational needs throughout New England. The first step in this process will be a needs assessment to be conducted during 2005. While this is occurring, the DTBPC will provide courses and training under the new umbrella designation.

In addition, RTMCC will develop a network of New England TB medical consultants who will be able to respond to requests for clinical consultation. Dr. John Bernardo, the Medical Officer for the DTBPC, will spearhead this effort.

The DTBPC looks forward to working with all of its partners in this exciting new endeavor.

TB In Massachusetts

In 2004, 284 cases (case rate 4.47 per 100,000 population) of tuberculosis (TB) were reported to and verified by the Massachusetts Department of Public Health, Division of TB Prevention and Control. This is a 9% increase compared to 2003 cases. Although there has been a 37% overall decline in the case rate since 1992, case rates had remained stable since 1996.

Nurse Spotlight

This issue of the Communicable Disease Update will highlight Infectious Disease Nurse Gin Lynch, RN, of the Hampden County Correctional Center (HCCC) in Ludlow. Gin went to work at HCCC because it offered a flexible schedule, and with two young children the hours worked for her. She stayed because of the patients. Gin retired on April 30th having completed twenty-one years at HCCC.

Prior to HCCC, Gin worked at Mercy Hospital in Springfield for seventeen years. While there, her varied responsibilities included assistant head nurse, head nurse and administrative supervisor of the emergency department.

In conversations with Gin, she stated that the favorite part of her job has been the interaction with the patients, educating them on health topics and watching them get better. Gin has always stressed teamwork with her patients. Caring for the patients and being committed and loyal to them is what motivates Gin most.

Gin's colleagues clearly respect and admire her: "Gin starts from the priority of helping people, and has much wisdom on how to best do this both for individuals and groups – and how connected this is. She is quite smart, very practical and realistic, appropriately compulsive, keeps a sense of humor, gets concerned but doesn't panic, can see around corners and connect and communicate with people – sometimes even when their ears are closed"; "Gin has excellent assessment skills, excellent nursing skills and a great sense of humor. One of the most important ways to judge her as a nurse is in her ability to communicate respect for her patients which she does in a caring and supportive way"; "Gin epitomizes the definition of a compassionate and dedicated nurse".

Gin is married and has a daughter, who is a lawyer, and a son, who owns a computer company. She is looking forward to traveling now that she is retired.

The TB Division is pleased to recognize Gin Lynch for her dedication, compassion and commitment to TB prevention and control in corrections and the community at large. Hampden County Correctional Center and the western Massachusetts region are fortunate to have had her as part of their public health team.

LGV
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mg of erythromycin base orally, four times a day, for 21 days. Some experts believe that azithromycin 1 gram orally, once weekly, for 3 weeks, is effective, however, clinical data are lacking.

Sex partners who had contact with the patient within 30 days of the patients' onset of symptoms should be evaluated. In the absence of symptoms, they should be treated with either 1 gram of azithromycin in a single oral dose or 100 mg of doxycycline orally, twice a day, for 7 days.

Recommended Approach

- Clinicians who care for MSM should consider LGV in the diagnosis of compatible syndromes, particularly proctitis. Other manifestations of LGV include tender lymph nodes (inguinal and/or femoral which can become fluctuant) and anogenital ulcers (small, generally painless ulcer followed by the appearance of tender lymph nodes)
- Contact the Division of STD Prevention if you suspect a case of LGV. We can assist in direct identification and serologic testing for CT in cases compatible with LGV as well as with partner management services
- Perform direct identification testing for CT
- Perform testing for *Neisseria gonorrhoeae* and other STDs (syphilis, HIV and HSV, as appropriate)
- Perform serologic testing for CT
- Cases compatible with LGV should be treated presumptively

For more information on specimen collection/testing and other assistance, contact Sylvie Ratelle, MD, MPH or Bill Dumas, RN, Division of STD Prevention, at (617) 983-6940.

World Refugee Day 2005

In 2001 the United Nations High Commission for Refugees (UNHCR) adopted June 20, as World Refugee Day, coinciding with Africa Refugee Day in a show of solidarity. In its four-year history World Refugee Day has focused on saluting and celebrating the indomitable spirit and courage of the world's refugees. This year's theme was *COURAGE*, in recognition of the bravery and strength of the 17 million refugees around the world who must rebuild their lives from nothing.

All across the globe, World Refugee Day was celebrated with a unique array of festivities and tributes that range from rock concerts to memorial services and conferences. In the United States, a week of events included an opening ceremony, photo exhibits, film screenings, lectures and musical and dance performances at the National Geographic Museum and Kennedy Performing Arts Center in Washington, D.C.

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concentrations of 30% or lower for older children and adults. Dispose of, or regularly empty, any metal cans, ceramic pots, and other water holding containers.

Reports of positive mosquito pools, animals and humans may be accessed on the MDPH website at www.mass.gov/dph/wnv/wnv1.htm. This website also contains educational materials on EEE and West Nile virus (WNV) for the general public, veterinarians, physicians and boards of health.

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Current and past issues of CD Update are available online at:
http://www.mass.gov/dph/cdc/update/comnews.htm

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